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ORIGINAL COMMUNICATIONS.

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DISEASES.

VOL. XX. SEPTEMBER, 1902. NO. 9.

Original Communications.

A POSSIBLE AID TO THE DISCOVERY OF THE TUBERCLE BACILLI IN URINE.*

BY J. P. BRYSON, M.D.,
St. Louis,
Professor Genito-Urinary Surgery, Medical Department Washington University; Surgeon St. Louis, Mullanphy Hospitals.

IN association with Dr. H. C. McC. Johnson, my then assistant, I have made within the past two years some observations which appear to demonstrate that under certain circumstances the bladder may be utilized as a collecting reservoir for entrapping and holding large numbers of tubercle bacilli when, in the course of tuberculous disease, these micro-organisms enter the urine-stream. In some of the cases observed the number of bacilli were so great and their arrangement such as to raise in my mind the suspicion that, under certain circumstances, these microbes might multiply in the pus- and blood-laden urine. This suspicion is all the more plausible when we consider that the bacilli are not killed by the urine and that they probably remain in

* This paper was read in the Section in Genito-Urinary Surgery, Congress of American Physicians and Surgeons, held in Washington, D. C., in May, 1897. Owing, in part to the temporary misplacement of the photomicrographs, but mainly to those demands on the time and attention of one in active practice which are well known to be hostile to satisfactory work of this kind, it has not been published. In the meantime, however, this method of utilizing this residual urine for bacteriological examination, as described, has been practiced by the writer, who has continued to find it to be of much service in determining the pathogenic factor in certain cases presenting an obscure symptomatology with little that could be depended upon as a result of physical examination. So cunningly does tuberculosis mimic other diseases—and especially those whose surgical treatment is quite different from what would be adopted once the diagnosis was assured—that any practical aid which does not involve a difficult technic seems worthy of consideration.

the albuminous secretions of the diseased bladder for a considerable length of time.

Attention was directed to the matter in an accidental way. It frequently happened in the course of routine office work that suspicion of tuberculous disease was not raised until the bladder of the patient had been emptied in the making of the "two-glasses" test or for other reason. It then becoming necessary to have some urine for bacteriological examination, a clean, sterilized catheter would be introduced for the purpose of obtaining it. This was often barely more than would fill the catheter, and, on hypogastric pressure, cause a few drops to fall into the test-tube. The soft catheter, squeezed so as to hold its contents safely, would then be withdrawn, its proximal end allowed to fall into the test-tube, and the urine to run out. It not infrequently happened that several drams of urine were obtained in this way, but that which filled the catheter was always added to the other. When Dr. Johnson called my attention to the fact that his examination of the specimens thus obtained almost invariably showed very large numbers of the bacilli, often arranged in clumps and bundles, but also singly and scattered over the field, we were at first disposed to think the fault lay with the catheter, or possibly that we were dealing with the smegma bacillus, or even that the glycerine used to lubricate the catheter might have contained them. The first and last having been corrected and the whole technic of the procedure having been carefully guarded, the result remained the same. When the bacilli were found they appeared in exceptionally large numbers.

We then instituted another series of observations, viz.: the bacteriological examinations of the urine voided naturally (tidal) and that drawn in the manner described (residual), for comparison of the relative numbers of the bacilli in cases which, for the most part, were well known to me to have tubercular cystitis, ureteritis, or pyelonephritis. I am enabled to present some photomicrographs with the slides from which they were made, showing the relative numbers of the bacilli in the tidal and residual urines. While photomicrographs cannot demonstrate fully the relative numbers of the micro-organisms, it being possible to introduce error by taking selected fields, an examination of the slides will demonstrate the distinct numerical disproportion, the greatest numbers being always seen in the urine drawn with the catheter.

Desiring to have the observation of others in this matter, I requested Dr. Mary H. McLean to make use of it in the case of a young lady now under her care, in whose urine, voided naturally, I had discovered the bacilli in scant numbers twice at intervals of a year. The patho-

logical diagnosis was in dispute, several specimens having been pronounced free of the micro-organisms by at least two competent microscopists, while another had rashly offered to stake his professional reputation on his purely microscopic diagnosis of non-tuberculous disease, all of which may go to show the difficulty of detecting them in certain cases in which there are other conclusive signs of the disease. Dr. McLean, taking the necessary precautions against error, sent me a few drams of the urine voided naturally, and a portion of that immediately withdrawn by catheter. The latter was forwarded by me to Dr. Amand Ravold, who reported under date of December 20, 1896. After announcing the presence of the bacilli in the urine, he was good enough to describe his method of procedure as follows: "The urine was centrifugalized, the sediment spread on slides and stained with carbolfuchsin solution, then decolorized with five per cent. sulphuric acid in twenty per cent. alcohol. Inasmuch as the bacilli retained the dye after the use of alcohol, which is said to decolorize the smegma bacillus, I believe them to be bacillus tuberculosis. They were found in unusually large numbers." The well-known unreliability of staining methods for differentiating the bacillus tuberculosis and the bacillus smegmæ did not of course permit either Dr. Ravold or myself to rest content with this, and we have made an effort to apply the inoculation test. Lack of time on my part has prevented the carrying out of this method except in one instance. Some of the urine voided by the patient just mentioned was given to Dr. Ravold, and used by him to inoculate a guinea-pig. He reports to me under date of April 30, 1897, as follows:

"The urine that I received from you January 5, 1897, was centrifugalized and the sediment obtained spread upon glass slides and stained for the tubercle bacillus, according to the method of Ziehl. The bacilli were found but not in so large numbers as in the previous specimen of December 22, 1897. Ten c.c. of the urine was centrifugalized and the sediment drawn off. One c.c. of this concentrated precipitate was injected subcutaneously into the abdominal walls of a vigorous male guinea-pig weighing 465 grams. Very little reaction followed. February 5th found a small nodule in the skin at the site of inoculation, about as large as a No. 5 shot. The animal did not appear to be sick and continued to increase in weight. April 7th I noticed that the pig was sick, was pale about nose and ears, breathing rapid, and had horripilation. It grew rapidly worse and died April 19th. A postmortem showed quite a large nodule under the skin at the site of injection, surrounding glands enlarged, and the peritoneum, liver, kidneys and lungs invaded with tubercles. The carcass was preserved in formol and so far I have not had time to make a microscopic examination of the

tuberculous tissue.* I am positive, however, that the animal died of tuberculosis induced by an injection of urine sediment containing tubercle bacilli, made by me January 5, 1897."

For the purpose in view at the present moment, attention may be directed solely to the relative number of bacilli found in the tidal and residual urines, and we may leave outside of our consideration the questions of the differentiation of the smegma bacillus, the anatomical source whence the tubercle bacilli were derived, the extent and virulence of the disease, the question of mixed infection, pyuria, hematuria, albuminuria, with constant acidity in purulent urines in which no tube casts are found, as well as the subjective and objective symptomatology of the disease in the pre-bacillary stage of the urine. We may thus narrow

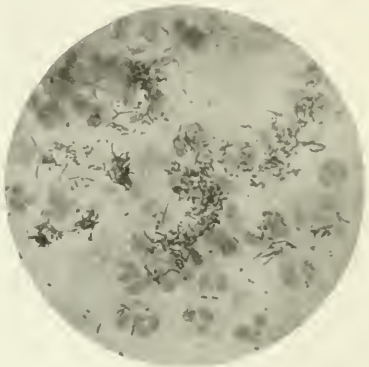

Fig. 1.—Residual urine. Case I.

our efforts to an endeavor to point out the probable practical advantage to be derived from the use of a catheter as an aid, in practice, to the discovery of the bacilli when they are present, from whatever their source. This purpose may be sufficiently accomplished by the presentation of five slides from as many cases, each slide having upon it a stained cover-glass preparation of the sediments derived from the tidal and residual urine.

In at least two of the cases noted below, I should have failed to discover the bacilli if reliance had been placed alone in the search of the

* Subsequent examination by Dr. Ravold demonstrated the tuberculous nature of the nodules. This patient has since developed, and is now the subject of, extensive, right-sided, tuberculous pyelonephritis.

sediment derived by centrifugalization of the tidal urines, and it is worthy of note that in both these cases they were found in unusually large numbers in the residuals drawn with the catheter. In both of these cases, also, the objective and subjective symptoms did not permit withholding the diagnosis of tuberculous disease.

Case I.—C. H. P., age 52. History indicated tuberculous disease of the uro-genitary organs of several years duration, which had been aroused into activity by at least two blenorrhagic infections. Nodules were discovered in both epididymes and in both lobes of the prostate. There had lately appeared symptoms arousing suspicion of tuberculous disease of the right kidney. Tuberculous, deep urethritis and cystitis

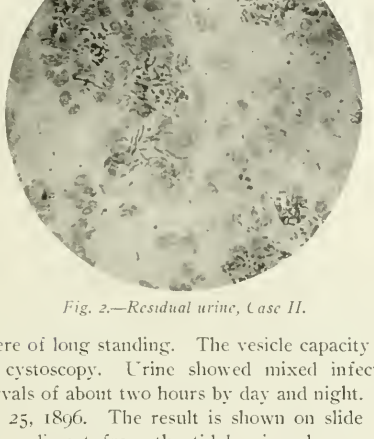

Fig. 2.—Residual urine, Case II.

of the neck were of long standing. The vesicle capacity was too small to permit of cystoscopy. Urine showed mixed infection and was voided at intervals of about two hours by day and night. Observations made October 25, 1896. The result is shown on slide 1. On cover-glass "A" the sediment from the tidal urine shows rarely a single bacillus; cover-glass "B,"* residual prine, shows bacilli in large clusters. (Fig. 1).

Case II.—Judge J. D. B., aged 43. History of tuberculous nodules in testes since childhood. No history of other infection. Had been treated by me for past four years, bacillus in small numbers having been found in urinary sediments on several occasions. Tuberculous prostato-cystitis, double epididymitis, funiculitis on right side. Within

* This patient died in 1899, of extensive tuberculous disease of the abdominal viscera, the lungs remaining unaffected nearly to the end.

past year evidences of ascending right tuberculous nephritis. Right testicle, completely broken down and causing great pain, was removed by me December, 1895. Observation, October 25, 1896, slide 2 sediment from tidal urine under cover-glass "A," shows no bacilli; sediment of residual urine under slide "B" shows a few bacilli (Fig. 2). At the time this observation was made the patient had greatly improved under constitutional treatment, both in general health and in his urinary symptoms. On the 25th of February, 1897, improvement

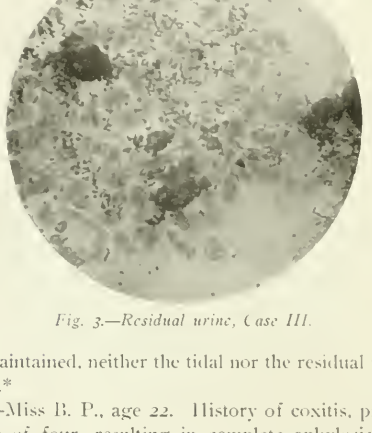

Fig. 3.—Residual urine, Case III.

having been maintained, neither the tidal nor the residual urines showed tubercle bacilli.*

Case III.—Miss B. P., age 22. History of coxitis, probably tuberculous, at age of four, resulting in complete ankylosis. History of cystitis for several years past. Tubercle bacilli found in tidal urine in winter of 1895 and 1896. Observation October 24, 1896. Slide 3, cover-glass "A" shows bacilli very rare; cover-glass "B," residual urine, shows bacilli in large masses. (Fig. 3.)

Case IV.—William S., age 32. Tuberculous nodules in left testis and cord. Nodules in prostate. Tuberculous cystitis of several years duration. Capacity of bladder five and one-half ounces. Distension-

* Patient, who has remained under observation, is now practically well. Evidences pointing to right-sided nephritis have disappeared, the urine has cleared and there are no nodules to be felt in the prostate, which is reduced in size as a result of the bealing of the disease. There remains, however, a small and quite tender nodule in the cauda epididymis of the left (remaining) testicle, connected with the cicatrix of a healed fistula. The result may be attributed to the persistent taking of creosotes with the hypophosphites. No climatic treatment.

reflex exaggerated. Observation December 3, 1896. Slide 4, cover-glass "A" (tidal urine) shows no bacilli; cover-glass "B," residuum by catheter, quite numerous bacilli. (Fig. 4.)

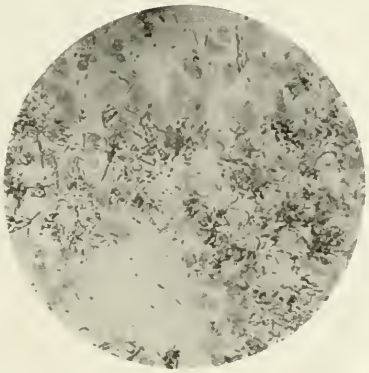

Fig. 4.—Residual urine, Case IV.

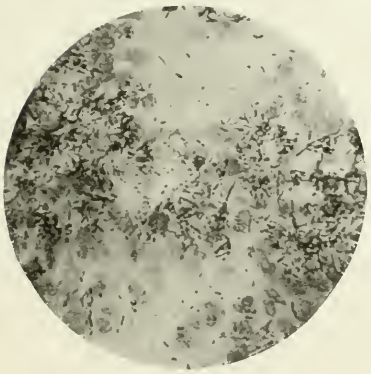

Fig. 5.—Residual urine, Case V.

Case V.—Dr. A. O. Y., aged 31. Evidence of tuberculo prostato-cystitis for past two years. Observation March 9, 1897. Slide 5,

cover-glass "A" (tidal urine) shows no bacilli;* cover-glass "B," from residuum by catheter, three drams, shows numerous bacilli. (Fig. 5.)

If any observations on the use of the catheter exactly in the manner described above have been published, they have escaped my observation. Some years ago Dr. F. Tilden Brown, of New York, courteously sent me a slide containing the largest number of tubercle bacilli, derived from urinary sediments, I had seen up to that time. If my memory serves me correctly, he stated in the letter accompanying it that the urine from which the sediment was derived had been drawn with the catheter. Whether the tidal urine had been voided previous to catheterization, I believe he did not state. I was therefore much interested to learn his method of proceeding in his use of the catheter in these cases. I presume he has fully set this forth in his article on renal tuberculosis, read before this Association at its last meeting and recently published in the *New York Medical Journal*. On page 452 of that journal, Volume LXV, No. 14, I find recorded his ingenious catheter test for determining whether the tubercle bacilli in a given case were derived from the posterior urethra or from above that point. He says: "I drew the urine by a sterilized catheter, allowing an ounce for cleansing the eye to run off uncaught." It is clear here that the catheter was introduced into a full bladder. In the course of the same article, page 481, same journal, he says: "The use of the ordinary bladder catheter for collecting urine for critical examination, particularly when an ounce or more is permitted to flow through it before making the collection, reduces to a minimum the chance of getting contamination from the glans penis, vulva, urethra, or seminal vesicles; but even the precaution mentioned does not wholly eliminate the possibility of error; even while the catheter is in place, reflux from the bladder or the vesicles may occur." The contamination here referred to applies to the smegma bacillus and the tubercle bacillus by reflux from the prostatic urethra. Nevertheless, in many tuberculous bladders to allow "an ounce or more" of the urine to flow before making the collection, comes very near to the collection by catheterization of residual urine. It does not, however, appear that Dr. Brown has used the instrument with the specific intention of getting only the residual urine for bacteriological examination, and he makes no mention of an effort by him to determine the relative numbers of bacilli in the tidal and residual urines.

The discovery and identification of the tubercle bacillus in suspected cases, which alone enables us to make a positive diagnosis, is beset with

* Cases 4 and 5 have been lost sight of. The observations in both cases here recorded are first observations, from which it may be seen that the identification of the bacilli, and hence the positive pathological diagnosis, was made only by the application of the method described.

many difficulties. In many cases, the pre-bacillary stage of the urine probably lasts a long time, and this is the stage in which our efforts to stay the progress of the disease might be expected to produce the best results in arresting the destruction of tissues whose restoration is not possible. In certain other cases of tuberculosis uro-genitalis, the bacilli probably never enter the urine-stream. Such are cases presenting tuberculous foci in the substance or about the periphery of the prostate and peri-vesicular spaces. The discovery of the bacilli in the urinary sediments derived from those rare cases of testicular and funicular tuberculosis presenting no evidences of the disease in and about the prostate and vesical neck is, to say the least, doubtful. In the earlier stages of certain renal, and even urethral and vesicular affections, the bacilli are probably not present in the urinary sediments at all; and the diagnosis of tuberculous disease is not, as a rule, otherwise well supported. Later on, when the disease is well established and considerable destruction of tissue has been accomplished, other well-known subjective and objective symptoms justify a diagnosis, even in the absence of the bacilli. Nevertheless, our attention should always be directed to their discovery in the urinary sediments, and any aid, however small, tending to this end, is of value in practice.

It would be of interest to know if, in those cases of primary renal tuberculosis, before descending bladder infection has occurred, the residual urine by catheter would show such results as are here recorded. A priori, one may doubt if the normal bladder would entrap and hold for any considerable time an unusual number of bacilli descending from the infected kidney. I have had no opportunity to make observations bearing on this point. From the standpoint of therapeutics such observations would be of high value, because, in this instance, bladder infection might be at least much delayed, and, in certain cases, absolutely prevented. These infections are usually on the surface of the trigonal mucous membrane and about the ureteral orifices, and proper treatment would probably be of much advantage.

CUTANEOUS SARCOID.*

By WILLIAM S. GOTTHEIL, M.D.,
Physician to the City Hospital; Dermatologist to Lebanon and Beth-Israel Hospitals, the Sheltering Guardian Orphan Asylum, &c.

IT is no exaggeration to say that the subject of sarcoma and sarcoma-like growths of the skin is one of the most unsatisfactory in the entire domain of dermatology. Clinical features, pathological findings, and therapeutic suggestions are often confused and almost contradictory; and even the classification and nomenclature of the affections under consideration are open to question. Are these dermatoses really sarcomas in any general pathological sense at all, and what are their relations to mycosis fungoides, leucemia cutis, etc.? How many different varieties are there, and what are their essential characteristics? What are the prognoses of the different kinds of tumor growth? And what, if any, is the treatment that offers hopes of therapeutic success? These are questions to which the text-books give but lame and insufficient answers. And the clinical and pathological work of recent years, painstaking and meritorious as it has been, has not, I think, tended to clarify our ideas. Thus Unna, in his very elaborate but hardly satisfactory pathology, (1) enumerates not less than eight varieties of sarcoma cutis. Jarisch (2) adopts the same classification. Johnston's division (3) is histogenetic only, as the author admits, and is of comparatively little use to the clinician, who requires a visible and palpable differentiation for practical use. Other more recent investigators, such as Boeck (4), Breakey (5), Koehler (6), Wende (7), Sellei (8), Delbanco (9), Massei (10), Sequiera and Bulloch (11), Philippson (12), Gaucher and Sargent (13), etc., describe a case or cases under various designations, but hardly elucidate the more general questions to which I have called attention.

I have had occasion during the last few years to see six cases of sarcomatous disease of the skin. Two were only in consultation, and gave me no opportunity for extended study or microscopic examination. The other four were under my care for extended periods of time, one of them for five years; and three of them are still under treatment. I propose to record them before attempting to give any con-

* Read at the Section of Cutaneous Medicine and Surgery, of the American Medical Association, Saratoga, June 11, 1902.

clusions; and since this would exceed the limits of a single paper, I shall devote this one to the case whose provisional title I have placed at its head.

The patient, R. S., was a Russian Jew, 64 years old, well built and well nourished, and in fairly vigorous health. His internal organs presented no abnormalities save a moderate chronic bronchitis. His complexion was clear and rosy, and neither skin nor eyes showed evidences of more than ordinary senility. Though he was quite intelligent, but little of importance in the way of previous history was obtainable. The only diseases that he remembers are a syphilis which he contracted 39 years before, which was treated at Riga, Russia, where he then lived,

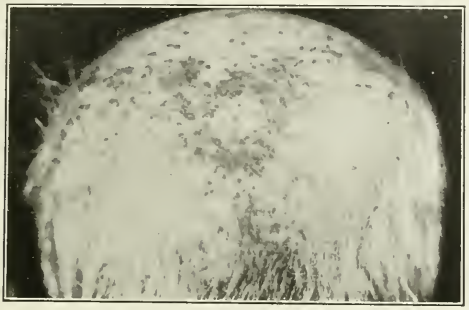

Fig. 1.—Macular eruptions on scalp.

and the depressed circular scars of whose tertiary manifestations were still visible upon his buttocks and thighs; and also a gonorrhea gotten in 1897, of which he cured himself.

He insisted that his skin had been perfectly clean and white until three months before the date upon which I first examined him with care, March 31st, 1901. He first noticed an itching or irritation upon the skin of the forearms, which was soon followed by the appearance of the eruption for which he came to the clinic. Examination showed the presence upon the body of two distinct sets of generalized lesions, and also of a deep ulceration upon the outer surface of the right heel. This latter, he said, came of itself a number of years ago; it had never been healed, though he had been in the German Hospital of this city for it for a considerable time, and had been subjected to all manner of treatment.

The dermal lesions were as follows:

1. A macular eruption. A large portion of the patient's body showed a closely aggregated eruption of faint, yellowish-pink macules, some of which were of a deeper hue, and a few of them distinctly brownish-black. They were most visible upon the flanks and arms, and upon his bald head (Fig. 1); there were none upon the face,

Fig. 2.—Cutaneous sarcoid. Papulo-tubercular lesions of the wrists.

palms or soles. The individual spots were irregularly circular, non-elevated, and some 2 to 3 millimeters in diameter. They looked like the lesions of a fading roseola, or possibly those of a faintly marked pityriasis versicolor or a lentigo. That they were not the first is proved by the fact that no luetic symptoms have been seen since he has been under observation, that the patient had indubitably had syphilis many years ago, and that the spots have remained absolutely quiescent, and are still present at this writing, some 15 months later. The entire absence of scaling, and of any trace of the characteristic fungus in sur-

face scrapings, disposes of all ideas of chromophytosis; whilst the location upon covered parts of the body renders it very improbable that the maculation is in any way allied to lentigo. He had not taken any medication at all for many years before the time of examination; hence the idea of an arsenical or other medicamental pigmentation is untenable. Of the existence of this eruption the patient himself was entirely unaware. (Fig. 1.)

Fig. 3.—Ulceration on heel.

2. A papulo-tubercular eruption. This consisted of a very hard, circular and sometimes almost hemispherical nodules, brownish-blue to dark purple in color, and of very varying size, scattered over different portions of the body. Some were as large as a small nut or bean; but most of them were pea-sized; and the very smallest of them seemed in some cases to merge imperceptibly into the more deeply pigmented spots of the macular eruption described above. All the visible tumors were apparently seated entirely in the true skin; none of them, so far as palpation could decide, involved the subcutaneous or deeper structures, and the integument was everywhere freely movable. But careful examination revealed the presence of a considerable number of invisible, deeper, and smaller nodules interspersed among the more apparent lesions. Some of the largest tubercles gave me the impression of being flattened upon their lower surfaces, as if growth had taken place mainly in an outward direction.

The lesions numbered hundreds altogether; but of the larger ones there were only a few score. There were none upon th scalp, neck, or ears. On the face there were a few not larger than peas on the forehead above the bridge of the nose, and a single bigger one upon the left side of he latter organ. Their color was not as deep as those upon

Fig. 1.—Cutaneous sarcoid. Fully developed nodule.

the body; but the patient affirmed that they appeared at the same time, and their other physical characteristics were precisely similar to them.

On each arm there were some six or eight large lesions; but the forearms and wrists were studded with tumors of all sizes, and there were a number on the backs of the hands. The fingers were free, but the palms showed several deeply seated and uncolored small nodules.

It was on the thighs, however, that the largest lesions were appar-

ent, together with numerous invisible and deeply seated tumors. The beginnings of their projection above the surface and purplish discoloration could be plainly traced, and all the stages of tumor growth could be distinctly followed. The legs were slightly edematous, and studded with numerous lesions. The backs of the feet showed a number of characteristic, hard, purplish, and elevated nodules; and the soles were in the same condition as the palms. The trunk showed only comparatively few but fair-sized tumors.

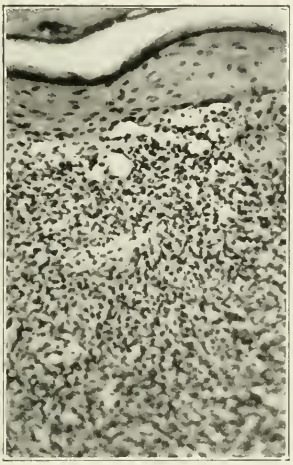

Fig. 5.—Cutaneous sarcoid. Centre of fully developed nodule.

3. A trophic ulceration. On the outer side of the right heel was a deep, walnut-sized ulceration of peculiarly sluggish appearance. An extensive area of skin surrounding it was greatly thickened, swollen, white, and looking as if macerated. The margins of the ulceration were deeply undermined; and the base was dry, insensitive, vividly red, and glazed. (Fig 3.)

The patient's dermal lesions were practically unaccompanied by any subjective difficulties. There was a little itching where the tubercular eruption was most abundant; but even the ulceration of the heel seemed to give him little concern, and did not impede locomotion. He claimed to have had a change of sensibility in the feet for two years; to have no feeling in them. But a careful examination failed

to reveal any marked change in the tactile or pain sensibility of the parts. His internal organs were healthy, with the exception of the physical signs of the chronic bronchitis above mentioned. The excreta

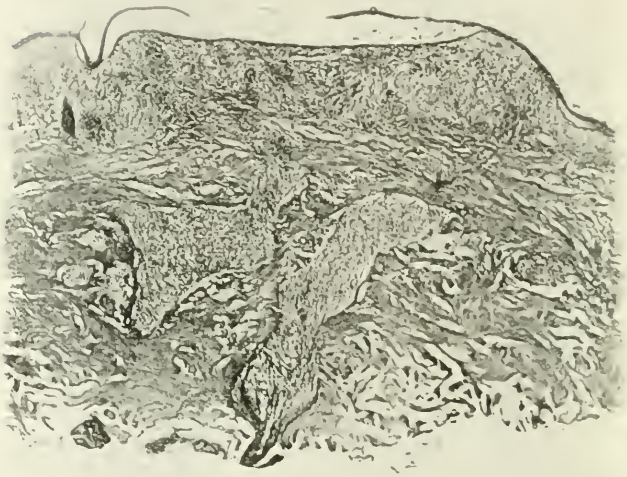

Fig. 6.—Cutaneous sarcoid. Retrogressing nodule

were entirely normal. An interesting point was the entire absence of any local or general adenopathy.

The results of the histological examination are shown in the accom-

panying photomicrographs (Figs. 4, 5 and 6). The nodules excised were beginning ones with their surrounding healthy skin; they were hardened and stained in various ways.

The new growth was found to consist of accumulations of cells of the connective tissue type, mostly round, though sometimes tending to become fusiform. Its beginnings in the perivascular lymph spaces could

Fig. 7.—Cutaneous sarcoid. Intercellular reticulum of retrogressed nodule

be clearly seen; and as they increased in number the cells gradually enveloped the vessel in a dense mass. The younger and smaller foci were all in the deeper layers of the corium; but as they grew they invaded the papillary layer, flattened it out, and thinned the epithelium. In all the larger foci the elastic fibers had disappeared; and here also the beginnings of the degenerative process to be noted later on were evidenced by the less perfect staining of the nuclei of the new cells and the appearance of granules in their substance.

During the next few months the patient was subjected to an intensive arsenic injection treatment, which, however, was unfortunately not continuous. During a number of weeks I had him in my ward at Lebanon Hospital; and at this time the gradually increasing dosage of the 1 per cent. arseniate of sodium solution reached the daily amount of 40 drops. He stood it very well, and showed no undesirable reaction. It was impossible, however, to keep him in the hospital indefinitely, and since his discharge he has had only the necessarily irregular dispensary treatment.

It was whilst he was in the hospital that the change in the lesions to which I now call your attention was first noted. Many of the nodules, especially the larger ones, begin to get soft in their centers, and to show a marked depression upon their surfaces. Their color also changed; the purplish tint gradually faded and they began to assume a lighter brownish hue. Some of them became distinctly yellow, and a number of them actually disappeared, leaving at their sites faintly pigmented and slightly depressed areas of skin. This involution was especially marked upon the face.

The next detailed notes were made on November 27, 1901, the patient having had but very unsatisfactory treatment for a number of months. Many nodules had entirely disappeared, but a number of new ones had sprung up, or perhaps it would be better to say that a number of the deeper-seated and invisible lesions had increased in size, and had become prominent and pigmented. This was apparent to the patient himself, who called my attention to the new lesions upon places readily accessible to his observation, such as the forearm. Several of the degenerating nodules were excised for the purpose of studying the process.

The change in the microscopic appearance was marked. The granular degeneration that had been noted in the centers of the larger nodules of the older specimens had spread to all the cells; they took nuclear stains badly, but above all they were diminished in number to such an extent that a delicate intercellular reticulum was plainly visible (Figures 7, 8 and 9). This was so marked in the most advanced lesions that instead of a densely packed mass of round nucleated cells, the field was occupied by a reticulum in which comparatively few cells remained. In the larger and more superficial nodules the surface of the growth became concave instead of hemispherical, and the epidermal covering was thinned out, loosened, and sometimes partially removed. Unfortunately none of the material was fixed in Fleming or other osmic mixture, so that no satisfactory examination for fat could be made.

Since the time that these last notes have been written the patient

has still been under observation, though hardly under treatment. As the nodules have almost disappeared from his face, and the affection causes him little inconvenience, he has apparently made up his mind that it is hardly worth troubling about. The malady is apparently running a benign course, and it is a question whether the atrophy of the nodules is not a spontaneous process, and entirely independent of the treatment that he has received.

I regard the macular and papulo-tubercular lesions as different stages of one and the same process, but I must confess to uncertainty as to the nature and significance of the ulceration of the heel. It antedates the other lesions by many years, and has not, I believe, any connection with them. The case in general is a fairly exact replica of that recorded by Bœck (14), with the exception of the absence of the lymphatic enlargement which was so marked in his patient. I have therefore designated it by the same name, though the term was originally employed by Kaposi in a much more extended sense, and by Joseph for a different class of sarcomas. In any case it stands as a representative of a distinct class of dermal new growths. Morphologically they are sarcomata, but they differ from other tumors of the same name in that their growth is limited and they increase only up to a certain point; that having attained that growth they then remain quiescent or undergo retrogressive and degenerative changes; that the general health is not impaired, and that metastasis to the internal organs occurs very late if at all, and that finally these are apparently the cases in which the administration of arsenic has given good results, as reported by Köbner, Kaposi, and others. The term sarcoid is appropriate, as showing on the one hand their morphological relationships, and emphasizing their clinical differences upon the other.

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A CASE OF HYPHOMYCETIC GRANULOMA OF THE SKIN.*

BY JAY F. SCHAMBERG, M.D.,

Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine. Assistant Physician to the Municipal Hospital for Infectious Diseases of Philadelphia.

MRS. L. D., age 40 years, was referred to the Philadelphia Polyclinic for diagnosis and treatment. She stated that for about four weeks she had been troubled with a skin disease on the arms. For a fortnight during the time that an ichthyol ointment was employed upon the affected area no extension had taken place; after the cessation of this treatment a rapid spread began. The patient first came under the writer's observation on Feb. 24th, 1902. At that time there were present upon the right forearm two large elevated patches. One of these was oval in shape and about 4 centimeters by 2 in diameter; the other was rounded and about 3.5 centimeters by 3.5 in diameter. The surface presented mammilated elevations almost papillomatous in character. The growths were half a centimeter or more elevated above the level of the skin; they were firm to the touch, and were quite tender. The placques were of a dull red color which hue extended to the skin immediately surrounding. Within the course of a few days a pustule developed upon the posterior surface of the arm about 3 centimeters from the round patch. This rapidly increased in size, became flat-topped and ruptured. Only a small quantity of pus was discharged; on removing the epidermal roof of the lesion it was seen that a small fungoid tumor of rapidly growing granulation tissue had almost completely filled the postule. The center of this growth was depressed in a sort of crateriform manner, whilst the borders were

* Read before the Section of Cutaneous Medicine and Surgery of the American Medical Association at Saratoga, June 10, 1902.

considerably elevated. New outlying pustules were developed from time to time following uniformly the evolution just described.

One of the smaller lesions was excised under local anesthesia; the operation was hurried owing to the incomplete loss of sensation and a small border of diseased skin, obscured by blood, was allowed to remain. A few days later rapid recurrence followed. Notes made at this time read: There is a recurrence of the growth in the wound of incision, the new formation being already larger than the original mass.

Fig. 1.—Photograph of the patient when she first came under observation.

New nodules which appeared several days ago have within 48 hours become half again as large as they were. From this time on the disease continued to spread until the posterior surface was about half covered with the fungoid growths. A new patch appeared anteriorly on the radial side of the forearm. At this time the arm and hand were quite swollen and a source of considerable pain. The extension occurred despite the use of various lotions and ointments containing carbolic acid, ammoniated mercury, bichloride of mercury, etc. The tincture of iodine was painted upon the growths twice a day for some days without appreciable improvement. The writer then advised the patient to enter the

hospital and have the lesions curetted away. Intimidated by the thought of an operation the patient delayed and was in the meanwhile persuaded by a friend to use a liquid and a powder given to her for some skin disease or other. This the patient did with the result that the disease immediately began to improve. Under the continued employment of these remedies the neoplastic elevations have flattened down and at the present writing, with the exception of some thickening in one of the patches are practically well. The applications used were a powder of acetanilid and a weak solution of permanganate of potash. The

Fig. 2.—Five days later, showing new lesions.

powder had doubtless little to do with the improvement, as this was dusted on the surface, which was practically always dry. The solution of potassium permanganate contained in the bottle brought for inspection was certainly not stronger than one to four thousand. Of this a teaspoonful was added to a quart of hot water and the arm was immersed in this for about twenty minutes twice a day.

The specimens were fixed in a 5-per-cent. formalin solution, hardened in successive strength of alcohol and imbedded in paraffin. Sections were stained with Haematoxylin-eosin, Fuchsin-picric acid, thionin, Weigertgram stain, carmine, gentian-violet, anilin, etc.

Microscopic and cultural examination.—Direct unstained smears of pus from the pustules were examined, but showed nothing of importance. Hairs from the affected region were examined under the microscope, but with similar result. The epidermal covering of the pustules were also subject to microscopic study. Cultures from the pus were tried upon agar and glucose agar without success. A growth of staphylococci was the only culture developed.

Inoculation of guinea-pig.—A fragment of the papillomatous growth about one centimeter square was torn away with sterilized forceps, placed in a test tube containing salt solution and a few hours later, under careful aseptic precautions, introduced beneath the skin of a guinea-pig. In the course of a few days a firm nodular tumefaction the size of a bean developed about the location of the tumor fragment, but this became gradually absorbed, the wound healed, and the animal showed no further evidence of local or general disturbance.

After the removal of the fragment from the arm of the patient a thick pus could be forced from the depth of the growth by pressure with the finger upon the surrounding surface.

Histo-pathology of an excised portion of the skin.—The corneous layer of the epidermis is in some places intact, in other regions it is largely absent. The malpighian stratum is greatly hypertrophied, extending in many places deep into the corium, the projections presenting a coralliform conformation. The rete is the seat of numerous abscess cavities filled with polymorphonuclear leucocytes (Fig. 1.) These are in some areas so large as to involve the entire depth of the mucous layer.

The entire corium is filled with an extensive and closely packed cell infiltration. In some areas this consists almost exclusively of lymphoid cells. In other regions there is a goodly proportion of polymorphonuclear leucocytes interspersed, while in still other portions the exudation is made up almost entirely of polymorphonuclear elements. The infiltration in some places is so dense as to obscure the fibrous stroma of the corium. Leucocytic detritus is present in some of the connective tissue cells evidencing a phagocytic process carried on by them.

The fungus is seen most abundantly in the spreading border of the tumor. In the epidermal abscesses none could be discovered. It consists of mycelial threads which take the gentian violet stain well. These threads are scattered throughout the cell infiltration in the corium. In some fields they are so abundant that twenty or more distinct elements can be counted. Some of them are wavy, but most are straight. They show in many places dichotomous branching and occa-

sionally a spore is present at the point of division. (Fig. 2.) Upon close examination under high power mycelial segments can be detected.

It is to be noted that many sections of the growth were examined without discovering the presence in them of any fungus elements. The portion of the growth used in the inoculation of the guinea-pig was not excised from the depth of the skin and may not have contained the fungus.

Fig. 3.—Showing appearance five days after photo No. 1.

In 1883 Majochhi wrote an article on "a complicated form of ringworm which differs both from sycosis and kerion. This is characterized by round, flat swellings of the skin, tender upon pressure but not painful, from the size of a bean to a hazel nut and covered with normal or slightly reddened skin. The consistence is first elastic, later soft and, indeed, fluctuating simulating subcutaneous abscesses. This condition is preceded by a herpes tonsurans. Histologically the growth is a subcutaneous granuloma made up of young granulation cell tissue rich in blood vessels, between which giant cells are found, giving to the tissue the appearance of cutaneous tuberculosis."

In 1887 Campana described under the name of "Trichophytiasis

dermica" the histological findings of a nodular elevation which was excised from an erythemato-squamous patch of trichophytosis on the scrotum. He found in the derma a few spores and some mycelial threads of the trychophyton fungus. No histological description of the excised lesion is given. It is possible that the nodule was an early stage of tricophytic granuloma.

Pelizzari (1888) reported a case of sycosis of the beard "consist-

Fig. 4.—Abscesses in epiderm and cellular infiltration in corium. (Zeiss apochromat. mm. 16, proj. ocular 2.)

ing of elevations of doughy consistence but with distinct softening in the center, covered with glazed, wine-red-hued skin from which the hair had been lost." Examination of the contents of the same showed in the yellowish red soft tissue juice, fragments of hairs which were penetrated with spores; the soft material was in the main made up of young granulation tissue.

Campana describes a second case of trichophytosis of the true skin, characterized by the formation of nodules which were made up of young granulation tissue and which contained giant cells.

(The above references are abstracted from the article by Pini.)

Pini (Archiv für Dermat. und Syph. 1890) describes under the title "Granuloma Trichophyticum Majochhi" three cases of *deep ringworm* infection of the skin.

Case I. M. B., a twenty-year-old peasant girl, had on the scalp, which had been shaved crescentic and coin-shaped patches of an erythemato-squamous herpes tonsurans: there were also present disseminated hemispherical elevations of various sizes (hempseed to hazelnut) covered with a glazed, tightly drawn, reddened hairless skin. The growths had begun eight months before. The family attributed the infection to diseased cattle.

Fig. 5.—Fungus in the cell infiltration of the corium. (Zeiss apochromat. mm 8 proj. ocular 2.)

Case II. V. G., aged nine, a peasant lad, had upon the flexor surface of the forearm a five-franc-piece-sized patch of trichophytosis, upon which appeared a reddish, glazed nodular elevation of linear form: two or three pustules were present in the middle of the patch. A brother suffered from tinea tonsurans and kerion. Probability of origin in cattle.

Case III. C. E., a seven-year-old schoolgirl showed between the calvarium and the fossa suboccipitalis, a group of seven discrete placques which were devoid of hair and flat, scarcely nodular. The color was wine red,—the skin smooth and shining. Palpation demonstrated a firm infiltrate which involved the entire thickness of the skin. (No bacteriologic or histologic examination of this case.)

In the first case Pini found under the microscope in the deeper

most layers of the corium an infiltration of mononuclear and polymorphonuclear leucocytes. In the center of this infiltration giant cells were seen. Trichophyton spores were found in scant number. No mycelial threads present.

In the second case isolated spores taking the saffranin stain were observed between the round cells. Pini obtained successful growths on glucose agar, glycerine agar, and acid potato. Inoculation experiments with pure cultures produced no granuloma.

Sabouraud (Annales de L'Institut Pasteur, June, 1893, page 527) in a study of the forms of trichophytosis with deep involvement of the skin, concludes as follows:

1. The special form of ringworm in children known as *Kerion Celsi,* the form involving the head known as *trichophytic circinate sycosis* and the variety designated *agminate perifolliculitis* are one and the same disease with merely different localization.

2. This disease is due to a special tricophyton which is able to produce this form of ringworm only.

3. Ordinarily this disease in man results from animal infection, and usually the horse is the animal from which the disease is contracted.

4. The disease in the horse is as a rule a *circinate folliculitis* similar to that in man.

Rosenbach in a monograph on Schimmelerkrankungen der Haut (Wiesbaden, 1894) describes a number of cases of trichophytic infection of the skin and classifies the fungi grown from them. The cases include ordinary tinea tonsurans, sycosic types, conglomerative pustular conditions and deep ringworm infections. A brief description of two of his cases is here appended.

Case I. A 31-year-old man had upon the left side of the chin a small nodule which increased in size despite treatment, developing into a circumscribed elevation, the size of a five-mark piece covered with crusts. Prompt cure resulted from curetting and thermocauterization. Extracted hairs and fragments of tissue inoculated upon nutrient agar gave rise to growths of the ringworm fungus.

Case II. A man of the same age had upon the cheek and neck about twenty pea- to thaler-sized, confluent nodules, some of which had developed into suppurating infiltrations. The disease healed only after 2½ months' treatment. The trichophyton fungus was recovered in culture.

Rosenbach remarks that superficial and deep forms of trichophytosis may result from one and the same form of fungus. He states also

that the clinical appearances of the deep ringworm infections may vary considerably.

Hartzell published (Jour. of Cut. and Gen. Urin. Dis., Nov., 1895, page 455) under the designation of "A Unique Case of Agminate Folliculitis of Parasitic Origin" a case of deep-seated trichophytosis of the skin. A man aged 32 had upon the leg a number of palm- and coin-sized, bright red, uneven, coarsely granular, elevated placques containing small openings from which there exuded by slight pressure a seropurulent fluid. New outlying lesions always began as pustules. Itching and pain were prominent symptoms. The disease appeared to have its origin in a pustule which developed upon a wound produced by a fall upon a sharp stone. Central involution occurred in the largest patch. There was evident involvement of the hair follicles. Microscopically the sections showed abscess cavities in the epidermis containing pus cells and epithelium in addition to a few spores and mycelial threads. The greatest changes were in and around the hair follicles: these were enlarged and distorted and presented large angular cavities filled with round cells, round and oval spores and an abundance of mycelium. The mycelium in some sections extended a considerable distance into corium. The fungus presented all the characteristics of the trichophyton although the individual elements were larger than usual. No cultures or animal inoculations were made.

Duhring and Hartzell (Amer. Jour. Med. Sci., March, 1895, page 283) describe a case of follicular hyphomycetous disease of three years' duration occurring upon the side of the neck of a lad of fifteen years of age. The eruption consisted of several patches of papular and papulo-ulcerative lesions, arranged in a crescentic manner and bearing a resemblance to a verrucose lupus vulgaris. The case differed considerably in its clinical appearance from the preceding one, but presented the same changes under the microscope. Similar inflammatory alterations were noted in and around the hair follicles, and the same kind of fungus was present in the tissues.

The cases above referred to present rather divergent clinical features. The most common types of deep trichophytic infection of the skin are those which belong to the groups of "agminate folliculitis" and "kerion." These cases are by no means rare and are seen from time to time by most clinicians. A greater interest attaches to those cases which present a distinct neoplastic appearance, for these may at times be regarded as malignant growths. They not infrequently present a papillomatous aspect which may suggest a resemblance to tuberculosis cutis or blastomycetic dermatitis.

I am not willing in the case reported to make positive affirmation

as to the trichophytic nature of the fungus found in the tissues, although the morphologic resemblance is strong. Owing to the failure to identify the parasite by cultural tests I have preferred to report the case under the title of "hyphomycetic granuloma."

AN INSTRUMENT TO DIAGNOSTICATE HYDROCELE.*

By Frederic Griffith, M. D.,
New York,
Surgeon, Bellevue Dispensary; Fellow of the New York Academy of Medicine.

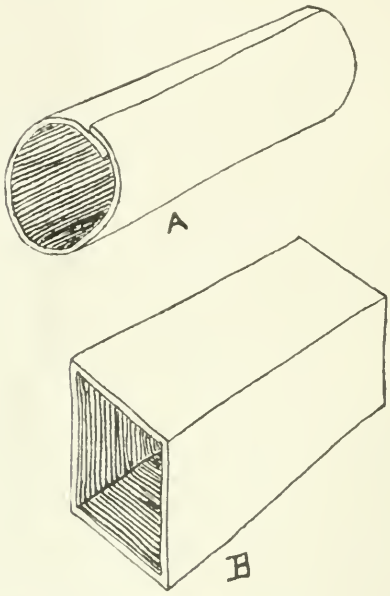
THE surest method of diagnosticating hydrocele is that by transmitted light, translucency being pathognomonic of this condition save for the few instances where the fluid becomes too darkly stained by blood pigment or when the tunic is greatly thickened.

To simplify this valuable procedure, which many clinicians neglect to employ, apparently owing to the difficulties involved, namely, that of securing a dark room, the author has devised what may be termed a hydrocele opera-glass.

The implement may be made of sheet cardboard or as improvised in the first instance in which I employed it by reconstruction of an adhesive plaster roll box, six inches long by three inches square at the ends, covered with black labeled paper (B). By slitting one edge with a sharp knife after removing the ends I was enabled to reverse the sides, forming a black interior and by the application of a few straps of plaster the box was held tight along the divided edge. This gave me an open-ended dark chamber which, when a lighted candle or taper was held in position with the scrotal tumor between it and the box end, with my eye at the other, I was able to clearly outline the scrotum contents. A later form (A) and one which I think will be more satisfactory for use is that of an open-ended hollow cylinder of pasteboard. Cut to a size of 6 inches by 8 inches from moderately heavy board, this when rolled and margin left for pasting makes a roll of handy size, 2 inches in diameter by 6 inches long. Before rolling the inner side must be blackened; this may be done by pasting a sheet of black paper or better, as it is more readily obtained, black muslin lining may be used, cut to size, or a coat of stove-blacking applied directly will give a dull finish black.

* Presented at the Genito-Urinary Section of the New York Academy of Medicine, April 16, 1902.

By having one of these instruments neatly made up on hand, at little cost, or improvised for the occasion, the surgeon will be grati-



fied by the results of its use when making a study of a case of suspected hydrocele.

805 Madison Avenue.

AMERICAN DERMATOLOGICAL ASSOCIATION.

Programme of the Twenty-sixth Annual Meeting, to be Held at Hotel Bellevue, 23 Beacon Street, Boston, September 18, 19 and 20, 1902.

Officers for 1901-1902: President, George Thomas Jackson, M.D., of New York; Vice-President, Joseph Zeisler, M.D., of Chicago; Secretary and Treasurer, Frank Hugh Montgomery, M.D., of Chicago; Council, George Thos. Jackson, M.D., Joseph Zeisler, M.D., Francis J. Shepherd, M.D., Hermann G. Klotz, M.D., Frank H. Montgomery, M.D.

FIRST DAY, THURSDAY, SEPTEMBER 18.

Business Meeting (with closed doors) at 9 A.M.

Report of Council: Nomination of officers for the ensuing year; appointment of Auditing Committee; report of the Committee on Nominations; proposals for active and honorary membership; miscellaneous business.

Morning Session at 10 A.M.

1. Address by the President, Dr. Geo. Thos. Jackson.
2. Cases of bullous dermatitis following vaccination, Dr. J. S. Howe.
3. An unusual case of epidermolysis bullosa hereditaria, Dr. G. W. Wende.
4. Four forms of generalized exfoliative dermatitis. (Erythrodermies, exfoliantes, généralisées, Besnier), Dr. J. T. Bowen.
5. A critical review of L. Philippson's proposed reform of dermatology, Dr. H. G. Klotz.
6. A case of pellagra, Dr. S. Sherwell.

Evening Session at 8 P.M.

7. Report of the committee on nomenclature.
8. A clinical study of 350 cases of nail affections, Dr. C. J. White.
9. The clinical aspect and treatment of some affections of the fingernails, Dr. F. J. Leviseur.
10. Note on the histology of herpes zoster, Dr. S. Pollitzer.
11. (*a*) A preliminary note on the frequency of pompholix in New Orleans; (*b*) a case of blastomycosis of the skin, Dr. I. Dyer.
12. Another instance of a disease caused by a fungus, Drs. D. W. Montgomery, Howard Morrow and H. A. L. Ryfkogel.
13. A case of cutaneous blastomycosis followed by laryngeal and systemic tuberculosis, Dr. F. H. Montgomery.

SECOND DAY, FRIDAY, SEPTEMBER 19.

Business Meeting (with closed doors) at 9 A.M.

Report of Treasurer and Auditing Committee; election of officers; election of active and honorary members; selection of time and place of next meeting; miscellaneous business.

Morning Session at 10 A.M.

14. General discussion: acne vulgaris; (*a*) etiology and pathology, Dr. T. C. Gilchrist; (*b*) symptoms and treatment, Dr. G. H. Fox.
15. The dermatoses occurring in exophthalmic goiter, Drs. J. N. Hyde and E. L. McEwen.
16. Dermatoses of the insane. Report of an examination of 1200 inmates of the Long Island State Hospital, Dr. J. M. Winfield.
17. Report of the Committee on Statistics.

Afternoon Session at 3 P. M.

(Harvard Medical School Building, 688 Boylston Street.)

18. Structure and mode of formation of the smallpox pustule. Lantern-slide demonstration, Dr. W. T. Councilman.

19. The value of radio therapy in cutaneous and other cancers. Illustrated with lantern slides, Dr. C. W. Allen.

20. Radio-therapeutic observations, Dr. J. Zeisler.

21. A further report on nævocarcinoma, Dr. A. Ravogli.

THIRD DAY, SATURDAY, SEPTEMBER 20.

Morning Session at 10 A. M.

(Medical Library Building, 8 Fenway). Exhibition of patients.

At the afternoon session on Friday there will be an exhibition of photographs, microscopical and other preparations, to which all members are invited to contribute, and of the Wigglesworth Collection of Baretta models. Members are requested to append a brief description to each article exhibited.

The attention of members is called to the ordinance of the association requiring that any member who shall read a paper before the association shall place a copy of the same in the Secretary's hands at the time of reading.

In case of unavoidable absence from the meeting, papers announced should be forwarded to the Secretary.

Book Reviews.

La Pratique Dermatologique. Edited by Messrs. BESNIER, BROCQ and JACQUET. Paris: Masson et Cie., 120 Boul. St. Germain, 1902. Tome II.

This volume is as large as the first. It contains 1058 pages with 21 colored plates and 168 figures in black and white. The typographical appearance and paper are really above all praise. There is one fault, prolixity, which certainly grows no less with our Gallic brethren and which will of necessity prevent systematic reading of these articles, a compliment they fairly deserve. It is hard to see how any busy man can manage to peruse the flood of literature which deals with skin affections.

Eczema.—After reviewing his great subject historically, Besnier plunges into a disquisition, illuminating enough, but difficult to give any idea of. The difficulty will be appreciated when it is learned that treatment alone covers a space of 150 of these large pages. He thinks that, to the word eczema, should be added eczematization, the first indicating a morbid entity, the second, an objective syndrome. It is far from easy to put the distinction into practice, but in the main it seems to be (I may be doing the author an unwilling injustice) that eczema appears without provocation while eczematization is never autonomous. Both are amicrobic, even when eczematization is secondary to parasitic "epidermodermitis," the term Besnier uses to indicate site as well as process. This underlying condition is one of irritability and lessened resistance to excitation from within or without, in the affected skin. Predisposition plays a large part. Arthritism is at the bottom of all eczemas called diathetic. The word has the definite meaning Bouchard describes as disorders of nutrition. In seborrheic eczema, idiosyncrasy is quite as great a causative factor. It has the same di-

visions as true eczema. The author thinks that the cardinal difference between true eczema and seborrheic lies in the depth of the initial process, the latter beginning on the surface. Three bacteria occur in seborrheic eczema symbiotically, but there is no adequate proof of a peculiar pathogenicity.

Electricity considered by Brocq and Bissérié is admirably full as to details of technic and apparatus. Many Americans will disagree with them on the question of failure of advance in the handling of X-rays. Methods are not perfect, but nearly enough so to warrant extensive use.

Epithelioma by Darier is disappointing in that it is not so complete as one might expect in a work of this sort. He makes several varieties of the ordinary squamous celled growth. Rodent ulcer and adenoid epithelioma are included. He treats only of secondary carcinoma, leaving the troubled nevus growth to another article.

Thibierge includes under artificial eruptions, those due to occupation, drugs, gastro-intestinal disturbance and to malingering. The illustrations are admirable and the text in keeping. Bodin goes a little out of his way in his article on erythema to include rubeoliform and relapsing scarlatiniform eruptions when Brocq, whose work in this line is so well known and so much appreciated, takes up the whole matter a few pages further on. Dubreuilh has divorced *esthesiomène* from its former meaning and uses it to indicate chronic vulval ulceration with hypertrophy of neighboring parts.

Sabouraud has, according to his growing habit, included nearly everything in the skin with pus in it under the heading of *folliculitis*, from tar acne and artificial eruptions to impetigo. Technically, the stand is correct; practically, the artificial divisions previously erected are useful and reference is in no way simplified by such treatment of a topic. This is the worst fault of systems. His statement that superficial folliculitis is due to the golden staphylococcus in pure culture is not worthy of serious consideration. The article on *impetigo* a little further on repeats his views previously printed in the *Annals*.

Leredde feels called on to erect a class of hematodermitis, meaning thereby diseases which may be due to toxic agents acting on hematopoietic or leucopoietic organs, *e.g.*, "dermatitis herpetiformis of Duhring-Brocq." (There are no discoverable apologies to Tilbury Fox for that appellation.)

Thibierge's *ichthyosis* is remarkably well done even in the midst of so much excellence. Like other authors of late he separates fetal from post-natal ichthyosis entirely. The reason for his inclusion of epidermolysis bullosa is not patent. Dubreuilh gives thorough consideration of *symmetrical keratodermias* and this volume is closed by Bénard's equally praiseworthy article on diseases of the tongue.

Jas. C. Johnston.

Society Transactions.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

Wednesday Evening, April 17, 1902.

JOHN VAN DER POEL, M.D., *Chairman.*

Epicystotomy for Tumor of the Bladder.—DR. WILLY MEYER.

DR. MEYER.—This patient, now 65 years, came under my care last year for an intermittent hematuria, which had existed for the last four years. He first discharged clear urine and towards the end a few drops of pure blood were pressed out. He had no pain at any time. When I saw him he urinated every 2 or 3 hours during the day, never during the night. He had a right inguinal hernia and a very marked chronic bronchitis. Of course in a case like this everybody would make use of the cystoscope; so did I. In looking into his bladder I saw one of the most beautiful pictures I had ever seen in the 15 years I have practiced this method. There was in the fundus of the bladder posteriorly and to the left of the mouth of the left ureter, about ¾ of an inch away from this mouth, a tumor the size of a cherry with an irregular surface, attached at its base as it appeared to me not by a thin, but rather by a broad pedicle. Such a picture is for a cystoscopist, of course, one of frequent occurrence. But there was in the center a dark blood coagulum adhering to the surface of the tumor and from the tip of one of the filaments, swinging to and fro in the injected boric acid solution, I could watch an active hemorrhage from a very fine artery. I could see the blood spurting out exactly synchronous with the pulsations of the heart and then slowly diffuse itself with the injected water.

The diagnosis of tumor had been surmised; of course nothing else but epicystotomy was indicated. I had first thought in a case like this to make use of the operating cystoscope. But I must confess, Mr. Chairman, although I am in possession of Nitze's as well as Casper's operating cystoscope, I still would prefer to do in a case like this radical work, viz.: open the bladder above the pubes and remove the tumor. So on the 9th of March last I opened the bladder by the suprapubic route. As I said before, the patient had a distinct chronic bronchitis. This induced me not to put him under general, but under spinal anesthesia. At the last meeting of the New York State Medical Society in October I reported on about 50 cases of spinal anesthesia I had done; whenever I made use of it I did it on clear indication. I used in this case the ordinary amount of cocaine—2 centigrams, and had a most perfect analgesia. I used the transverse skin and fascia incision and then opened the bladder by a rather long cut, in order to get thorough access. I found the tumor of exactly the shape and in the place previously diagnosed. Then I hooked the bladder wall with two single bladed rongeur forceps and pulled it right into the wound

in order to have full access to the pedicle. It could be very readily seen that two blood vessels ran through the vesicle wall to the base of the tumor. These were primarily surrounded by a catgut ligature with the help of a round needle, because I have frequently seen in vesical operations that after the pedicle is thoroughly extirpated or removed in some other way there is quite some profuse arterial hemorrhage. I think that by means of the method just mentioned, I avoided such an occurrence. Then I used that method which I prefer in operating for tumors of the bladder which have not a small pedicle. I used the covered Paquelin cautery knife and lifted out the base of the growth in connection with about ½ inch of the bladder wall. There was no hemorrhage. No further ligation was necessary and I could proceed to give proper attention to closing the bladder. I think that wherever a wound has been made with the actual cautery, it is better to drain, not to close it entirely by sutures and drainage with the permanent catheter introduced through the internal meatus, or as others might prefer through perineal incision. I have seen in one case continuous spasms in spite of large doses of morphine and decided never again to suture entirely if I had made a large wound with the Paquelin cautery. I used the method of Kader, as proposed by him for making a gastric fistula watertight and lately recommended with regard to vesical suprapubic drainage by Dr. C. L. Gibson of this city; that is to say. I first closed the vesical wound by a double row of catgut sutures up to a small hole, through which the drainage was introduced, which in turn, was surrounded by a double fold of the vesical wall, with the help of silk sutures. Then the outer wound was closed as far as it could be done and the pre-vesical space drained by a small strip of gauze. The man, after having overcome the fever so often seen following spinal anesthesia, (lasting 48 hours), made a good recovery. I removed the tube at the end of the first week. After this the whole wound closed rapidly, there being no leakage whatever. I saw the patient again a few days ago and he stated to me that he now urinates about 5 times in 24 hours and not at all during the night. The water is entirely clear; he never passed blood again. This specimen is preserved in alcohol. It has shrunk somewhat; it still shows nicely how the bladder wall had been shelled out with the Paquelin cautery. The man did not wear a truss for his inguinal hernia, as I ordered him to do. I am happy to say he has no additional hernia as a result of the incision. Microscopical examination showed the base of the tumor to be cancerous and the other part papylomatous. I have not examined the patient with the cystoscope again. I had no chance to do so. I may mention another case of cancer of the bladder where I have removed a tumor very similar to this one, in 1890, although the base was a little bit broader than the one here removed, in a man then 54 years old. For ten years I considered that case my star case, because there was no recurrence. In 1900, ten years after the operation, recurrence set in. When I saw him again his bladder was filled with carcinomatous masses. He was operated, also under spinal anesthesia. He died a few months later from chronic pyelonephritis. Such a case proves how careful we must be with our prognosis in cases of this class.

Hypertrophy of the Prostate, Cured by Bottini's Operation. — DR. WILLY MEYER presented a patient on whom he had performed the Bottini operation.

I had the good luck of seeing this patient again four years after the opera-

tion, after not having been able to examine him during this entire time. I think that if anybody presents a case of this kind before a gathering of medical men, it is due to them that he make an exact statement with regard to the former history and compare his former condition with the present one.

S. F——, fifty-two years of age. In August, 1896, after ingestion of a great deal of ice-cold liquid, he first experienced trouble in micturition. A physician advised sounding and irrigation of the bladder. Infection followed, also inflammation of the right testicle. There was a call for micturition every half-hour to one hour day and night. At one of our public hospitals vesical irrigation was carefully carried out for many weeks. In December the right testicle was removed. After the operation the patient was somewhat improved. The frequency in micturition decreased and the urine cleared up. But in April, 1897, recurrence of the former symptoms with considerable pain in the suprapubic region set in. Urination occurred about every forty-five minutes; dysuria was present. Little improvement followed, though the bladder was continually washed for a whole year.

When I saw the patient on April 28th, he urinated every fifteen to thirty minutes in the daytime; nights every hour to an hour and a half. With some effort he passed at my office 150 c.c.; residual urine, 175 c.c. The catheter, left within the bladder, after the latter had been thoroughly irrigated until the water returned clear, soon gave exit to a small amount of turbid urine. There surely existed pyelitis. The prostate on rectal palpation was found to be equally enlarged in both lateral lobes, and sensitive. Its upper border could be reached. As a result of urinary analysis a diagnosis was made of secondary hyperemia of the renal parenchyma or more marked lesion; chronic cystitis without alkaline fermentation. Cystoscopy showed a large prostate, trabecular bladder; probably pyelitis on the left side, as the urine expelled from the left ureteral opening appeared cloudy.

May 7th, Bottini's operation was performed at the German Hospital.

The first two days following the operation the patient felt very much benefited. Whereas he had had to get up during the night every hour to an hour and a half to urinate., and that always with pain, micturition now was at once rendered easy. Thus the report of the night from the 18th to the 19th of May was: The patient voided urine voluntarily between 10 and 11 P.M.; next between 3 and 4 A.M.; and next at 6 A.M. Using the patient's own words, he "certainly passed the best night for the last twenty months." On the third day the traumatic irritation of the gland began to produce greater frequency of micturition; then incontinence appeared for a short time, most prominent during sleep. There was no vesical irrigation; urotropine was administered internally. A short time after the operation the patient left the hospital. He had no further local treatment. On June 15th he reported at my office. He urinates every hour and a half to two hours during the day, but he could wait longer if he wished; during the nights, he waits about three to four hours; at times he has to strain rather long before the bladder is completely emptied. The former pain has disappeared. He feels and looks better, and has gained in weight. On September 22d he stated as follows: In July and August he was in the country, where he became much improved. He now urinates three to four times during the day, once or twice during the night. He passes at times 300 to 300 c.c. He voided at my office 175 c.c. of clear, gold-yellow urine, with residual urine, 125 c.c.; 250 c.c. of boric solution was

injected into the bladder and afterward passed voluntarily, without pain or trouble, in a good, strong stream, up to the very mark of the graduated glass. October 24th, the same good condition continued. He urinates from four to six times in twenty-four hours, and believes that, with some patience, he always empties the bladder. He passes 325 c.c. of perfectly normal urine within about two minutes; residual urine, 75 c.c. Of 350 c.c. of two-per-cent sterilized boric solution then injected he discharges 225 c.c. in a forcible uninterrupted stream, and then, with two short intermissions, 125 c.c. more. Not a drop is retained.

I did not see him again until lately. He told me that he passed water 3 or 4 times during the day and not at all during the night; feels entirely well. Now I want you to see how he urinates and I hope he will do us the favor. I presented this patient a short time age before the Surgical Society, because, I think, one patient cured proves more as to the value of an operation that 100 failures. I did not want to catheterize him before the audience, on account of maintaining asepsis, so the Surgical Society appointed a committee of one, in the person of Dr. F. Tilden Brown, to come to my office and be present when I catheterized the patient. This I did a few days ago, when the patient passed 375 c.c. in a short strong stream and the catheter found 5 c.c. in the bladder; then 300 c.c. of Ichthargan 1 to 5,000 were injected; he passed 280, so 20 c.c. remained. That means to say his residual urine is about 1 oz. to 1½ oz.

I think if a patient, who had all the symptoms of an enlarged prostate and consequent troubles, passes perfectly clear water three or four times in 24 hours, not at all during the night, without any trouble or straining, and has a residual urine of a bout 30 to 50 c.c., we have a full right to pronounce such a case cured. I think such acase is of great importance inasmuch as a great number of our colleagues have claimed that Bottini's operation can *not* cure a patient with a prostatic hypertrophy. If this case which I just happened to reach can be presented as cured, the demonstration of cure by Bottini's operation has been successfully done, and the claim is properly founded. Of course it is easy to explain why surgeons prefer prostatectomy to galvanocaustic prostatotomy. In hospital cases I decidedly prefer prostatectomy.

If patients operated upon by Bottini's method do not remain under our care for three weeks, and are treated by orderlies, if need be for regular catheterization and irrigation, there will probably be more failures than cures; and furthermore, at the end, it is many times more simple to do prostatectomy on a patient than to perform Bottini's operation. If we have done prostatectomy successfully, our work is done and every house surgeon and assistant can attend to the patient if necessary. In the Bottini operation it is entirely different. I have never had so much work on patients, day and night, as I have since I have done Bottini's operation. It may be due to the personal attention which I give to these cases; but that is, I think, the principal cause of my success in these cases, but also one of the causes why surgeons are so much adverse to doing Bottini's operation. The point to be emphasized here is: Galvano-caustic prostatotomy must become a recognized radical operation for the relief of hypertrophy of the prostate. We all must know and must recognize that we have two treatments with regard to the cure of hypertrophy of the prostate,—prostatectomy and Bottini's operation. To prove unmistakably induced me to bring this patient here to-night.

DR. FREDERIC GRIFFITH presented a case of apparent cure of hydrocele by the employment of the drop method and gave the history as follows: D. R., male, aged 45 years, a groom by occupation, is married and father of ten children.

Denying all venereal infection he came to me in February last presenting the signs of hydrocele upon the left side of the scrotum. The patient had been tapped for a similar condition one year ago and again four months previous to his first visit to me. Under antiseptic precautions I tapped and drew off 16½ fluid ounces of the typical hydrocele fluid. By means of a hypodermic syringe I injected one drop of pure carbolic acid, following the suggestion of Dr. Coley, with a result obtained which seems most satisfactory. The secondary inflammation which marks the success of injection treatment for hydrocele was pronounced in this case, lasting several weeks, though the patient was enabled to continue at work through the entire treatment. He now presents a condition of the parts but little changed from the normal. I am impressed by the difficulty in removing all of the fluid from the sac in these cases, so essential in treatment by minute quantities of the injecting fluid.

A point in the diagnosis of hydrocele which is invaluable, though not sufficiently employed, is that of study by transmitted light. Owing to the difficulty of securing a dark room for the study of these cases surgeons neglect to employ this means. To overcome the inconvenience of this requisite I would like to show an instrument, simple in construction, which allows the diagnosis of hydrocele to be made with facility. By means of a roll of pasteboard or an open ended box similar to the holder for rolled adhesive plaster. Placing the scrotom between the candle light and the end of the roll or box end, with the observer's eye at the other, a dark chamber is obtained which will demonstrate translucency of the scrotom, if present.

Winkelmann's Operation for Hydrocele.—DR. VAN DER POEL.

The only point I would make as regards this case is that I left a small rubber tissue drain in the lower angle of the wound extending upward for about an inch, instead of closing it entirely, there being primary union throughout; and in consequence of this, by means of granulation, I think the union between the anterior surface of the testes and the subcutaneous tissue is stronger. Ordinarily the testes will adhere to the subcutaneous tissues as it is brought up against them, but in this way, it is a little more apt to do so, and there will be a little less chance for a recurrence of the fluid.

Koehler's Operation for Varicocele.—DR. VAN DER POEL.

Koehler's modification for operation for Varicocele is simply where the radical operation of removal of a section of the veins is done and the skin incision is united transversely instead of in the original longitudinal direction. In this case, the stumps of the ligated and excised veins were also united. The lower angle of the wound was then made to approximate the upper angle, and a V or wedge-shape piece of skin removed from either end latterly, to make approximation better. This results in a transverse wound, and gathers up a considerable portion of the scrotom, which in this case was unusually long, and when combined with the suturing of the stumps, will often do away with the necessity of ablation, which we not infrequently have to do in these cases.

DISCUSSION ON DR. MEYER'S CASE OF EPICYSTOTOMY FOR TUMOR OF THE BLADDER.

DR. GOLDENBERG.—I would like to ask Dr. Meyer if he prefers epicystotomy to the intravesical operation in every case of tumor of the bladder. I am inclined to think that one with the great skill that Dr. Meyer possesses in cystoscopic work cannot be deterred from intravesical operations by the difficulty which he expects to encounter, but presume that his reason for not doing

so is due to the fact that he is afraid of relapses. I ask this question because Dr. Nitze in Berlin in course of a correspondence I had with him some time ago assured me that from his large experience—he had up to that time operated on 75 cases of tumors of the bladder—relapses are rare and certainly not more frequent than after epicystotomy.

DR. FULLER.—I consider that Dr. Meyer did right in opening the bladder suprapubically, removing the entire tumor and resecting a bit of the bladder about the base of the pedicle. I do not think snaring or scraping away these growths by means of one of the various operating cystoscopes sufficiently radical. Many of these growths which primarily appear histologically benign after a lapse of time either develop malignant characteristics, or, are followed by cancerous vesical manifestations. I recently performed a perineal prostatectomy through the employment of spinal anesthesia most satisfactorily. In this instance a lung lesion rendered the giving of a general anesthetic undesirable.

DR. VON GLAHN.—Dr. of the Necker Hospital, published a small pamphlet a few years ago on the statistics of the evident results of operation on tumors and showed that in the Necker Hospital for the average of 5 or 6 years it would have been much better to have left the patients alone. They all died as soon as if they had all been left alone. They all had recurrence.

DR. GOLDENBERG.—I beg leave to take issue with what Dr. Fuller has stated. In the first place, Nitze's operation is a thorough removal of the tumor with cauterization of the base.

In the second place, as to the relapses after operations on tumors of the bladder, performed at the "Hôpital Necker," the report from this hospital does not refer to intravesical operations but to the usual surgical procedures for tumor of the bladder.

DR. VAN DER POEL.—Last summer, in Berlin, through the kindness of Dr. Knoor, I had the good fortune to cystoscope a case, of about the same age as Dr. Meyer's from whom, a papilloma of the bladder had been removed with the electric snare, by means of the Nitze operating cystoscope, some six months previous, on account of hemorrhage. After removal, the base had been cauterized. Examination had shown the growth to be of a benign nature, but I found that it had returned, and was at the time I saw it about the same size as before operation, though the bleeding had as yet not recurred. I have a photograph of the recurrence as it appeared when I saw it, and cite the case to show that recurrence does occur after the snaring operation, even after the base had been cauterized.

DISCUSSION ON DR. MEYER'S CASE OF HYPERTROPHY OF THE PROSTATE, CURED BY BOTTINI'S OPERATION.

DR. FULLER.—The result in this case seems very satisfactory. The patient urinates absolutely freely and empties his bladder. There is a point or two however to bring about the case. One would have a right to question how much of the obstruction in this instance was due to inflammatory tumefaction rather than to senile hypertrophy. The man is rather young for senile hypertrophy. If I remember rightly, the history Dr. Meyer gave was that the retention came on suddenly and had not been preceeded by symptoms of obstruction. In most instances of obstruction from senile hypertrophy the obstructive symptoms develop more gradually. In this case the inflammatory trouble with the testicle

might lead one to infer a like condition of the prostate. I have in mind numerous instances of men in the early fifties, or younger, who as the result of a debauch, have suddenly developed retention and who after a short period of catheterization, have again recovered the function of urination as perfectly as in this instance, as the result entirely of expectant treatment.

Every one I think admits that the Bottini operation is applicable only to certain selected cases and cannot be used at random in all forms of prostatic obstruction. Prostatectomy is applicable to all cases and when properly performed the results from it are very satisfactory. Dr. Meyer has done much with the Bottini operation and has accomplished brilliant results in numerous instances.

DR. SWINBURNE.—I agree with what Dr. Fuller has said and think it would be interesting if these cases operated on by the Bottini method with greater or less success, can be followed for a number of years, to know whether the residual urine which they now have and which is slight is likely to increase through further hypertrophy or congestion. This patient is able to urinate easily and there is no question about the benefit received, but whether such cases are liable to a further hypertrophy which will in the future cause further trouble is an important question.

There is no question, as Dr. Fuller says, that some of these cases with acute retention, go on without further trouble for a number of years after they get relief by catheterization a few times, and then gradually have the symptoms of hypertrophy or obstruction come on.

DR. GOLDENBERG.—I do not want to take any sides with either the Bottini operation or prostatectomy, having no personal experience with either operation; but I would say that in a number of cases of hypertrophy of the prostate that I had the opportunity of observing for a number of years, good results were obtained and maintained by conservative symptomatic treatment, viz.: Regular catheterization and irrigation of the bladder. I like to mention one case in particular, because Dr. Meyer had seen this case with me in consultation. It was a patient seen 4 or 5 years ago, with absolute retention, in whom in spite of all aseptic and antiseptic precautions, every catheterization was followed by severe chills and general malaise. This patient was catheterized at regular intervals and passes now clear urine with perfect ease. I catheterize him about once a month, because he does not empty his bladder entirely, but the amount of residual urine is very small, the urine clear, micturition easy and the patient is free from all subjective symptoms.

DR. MEYER.—The use of Nitze's operating cystoscope certainly is very tempting to a man who is used to deal with this kind of cystoscopy. I have used Nitze's operating cystoscope, but was often annoyed by our inability to wash the lens and prism clear of blood. No arrangement has been made in the instrument to do this. If a small blood-clot has settled on lens or prism and irrigation through the tubes does not remove it, we are obliged, at present, to remove the whole instrument from the bladder, clear it, irrigate the viscus and reintroduce. The size of that cystoscope is a pretty large one,—about 26, French scale. From all I have seen in other cases, where a very thorough removal of a vesical tumor had to be done surgically, I think that the chances for the patient are infinitely better by opening the bladder. The fact is well known, that the base of a papilloma is often carcinomatous. I think I will use the operating cystoscope in exceptional cases only, where we are absolutely sure that the papillomata is benign, including its pedicle. Casper's operating cystoscope I have not tried so far. Certainly both Nitze's as well as Casper's

are very ingenious and will forever keep an important place in the instrumentarium of a cystoscopist.

With regard to recurrence I should like to say that in the majority of cases of cancer of the bladder there is unfortunately a recurrence. And yet, if we have seen patients remain entirely well, as I have mentioned before, for 9 years, after extirpation of a cancer of the bladder, enjoying life, as I think has been the case in the patient operated on by me in 1890, and another one of my patients with a large carcinoma of the bladder, verified by microscopic examination, now still enjoying good health six years after suprapubic extirpation, I think certainly the chances are in favor of extirpation.

The majority of these cases come too late for operation. The family physician must make it his duty to have the diagnosis as to the source of the bleeding promptly settled in every single case of hematuria.

With regard to the second cystoscopy, Mr. Chairman, some time after operation, I would like to ask whether you have seen the recurrence in the same place where the operation had been done?

CHAIRMAN.—The recurrence was in the same place.

DR. MEYER.—I have seen many cases of papillomata which sprang up rather quickly in the neighborhood of the seat of the primary disease.

CHAIRMAN.—I did not see the original tumor, yet Dr. Knoor told me the recurrence was in the same place. I saw the recurrence.

DR. MEYER.—I think that multiple vesical papilloma in a great many cases must be considered of malignant type, akin to papillomata of the larynx.

Now in regard to the second case—that of Bottini's operation, I cannot expect you to listen to all I would like to say on the subject. I first want to mention that this patient had no after treatment whatever. He represents a somewhat exceptional case, in that a patient who had not been treated later should have such a clear urine. I have, however, a number of cases of Bottini's operation besides this one where that has occurred; but I must also say that the majority of these patients need prolonged after-treatment to overcome the catarrhal condition of the bladder. Very few will submit to it. They disappear soon after leaving the hospital to clear up their urine.

I would venture to differ with Dr. Fuller with regard to the rarity of the first symptom of hypertrophy being sudden retention. Amongst quite a number of my cases the very first symptom of the presence of an enlarged gland, hitherto unknown to the patient, was retention. That happens, I think, frequently. I certainly have seen it very often, and this was the case in my own patient. I want to say that all the pathognomonic clinical symptoms of enlarged prostate were fully developed in this case. The cystoscope showed the body of the prostate bulging into the lumen of the bladder; there was at the neck of the bladder, visible through the cystoscope, that deep furrow, proving, according to Nitze's first demonstration of this class of diseases, that this was a true hypertrophy; and furthermore, he had a marked trabecular bladder. An inflammatory process of the prostate would not produce such a marked thickening of the detrusor muscle. I have never seen this trabecular condition of the bladder except there exists a true chronic mechanical obstruction to the outflow of the urine. The continuous pressure of residual urine in cases of prostatitis also is not seen. It is found in cases of prostatic abcess only. This patient was infected by continuous irrigation and during after treatment developed an abscess of the testicle, for which the latter was removed. I can further say, gentlemen, that on massaging the prostate in this patient not a drop of prostatic fluid was dis-

charged from the external meatus. There can, therefore, not be the slightest doubt that this was a true case of prostatic enlargement and that the patient was entirely cured by means of Bottini's operation.

With regard to suffering: not every patient suffers. A number do suffer, but we can relieve their suffering immensely by regular catheterization and irrigation. Suffering exists in many instances of this class of cases with regard to the attending surgeon. He must be alert and must expect more trouble than if he had done prostatectomy. If he goes and simply gives after the operation his orders to the house surgeon and tells him to go ahead as he thinks best, the percentage of deaths after the Bottini operation will be more than five to eight per cent., the usual percentage of fatalities after this operation.

Dr. Fuller states that he has about the same result in cases of prostatectomy. Whether he would venture to tackle a man of 90 or 92 years with prostatectomy I don't know. (Dr. Fuller: 81). But a patient at 92 has been successfully operated on by means of Bottini's operation. I am absolutely sure that in spite of the dexterity we can acquire during the course of years in prostatectomy we can not enucleate a soft prostate, a prostate which after having been hooked can be fully compressed. I now have had more than 60 prostatics operated with prostatotomy. Amongst them was quite a number of cases where I was amazed at the compressibility of the gland. If I had not seen the gland with the cystoscope before, if I had not myself previously felt the enlarged gland per rectum, I would then and there during the operation have claimed that there did not exist hypertrophy. It will be pretty difficult to enucleate such a gland and yet just in these cases you may have a good result with Bottini's operation. If I had a case of fibrous enlargement, a hard prostate, even if the patient be 74 or 76, I would do prostatectomy, eventually, under spinal anesthesia. Certainly that is the best way to get rid of a tumor, which we can remove just as well and much more easily than we are used to shell out an enlarged thyroid gland. I was very pleased to hear the remark of Dr. Fuller, namely, that Bottini's operation was applicable to a certain number of cases of enlarged prostate. He did not admit this a few years ago. The point, always to be emphasized, is, that there are now two operative procedures to cure or at least alleviate the troubles of prostatics, without regard to their age: prostatectomy and Bottini's operation.

DISCUSSION ON WINKELMANN'S OPERATION.

DR. BERG.—There have been recently reported a number of recurrences, I think four, after the Winkelmann operation.

DR. MARTIN W. WARE.—This operation, generally credited to Winkelmann, was originally devised by Doyen and Jaboulay, both of Lyons. It was subsequently taken up by the surgeons of Paris and modified. The difference in the two methods is that the Lyons school practices a decortication, whereas the Parisian school does not do this at all.

I have twice done this operation, but the time elapsed is not sufficiently long to pronounce its being absolutely successful, although reports show that there are a number of recurrences.

DR. MEYER.—Have you seen many cases of inflammation of the kidneys following this operation.

DR. VAN DER POEL.—I have not.

DR. MEYER.—I have seen it in a number of cases.

DR. VAN DER POEL.—You mean this operation I did here.

DR. MEYER.—I mean resection of the vas.

DR. VAN DER POEL.—Yes, that I have seen.

Non-Gonorrheal Urethritis.—JAMES C. JOHNSTON, M.D.

Urethritis is divided by the author into a number of classes according to their etiological factors. In each class, an illustrative case was given in detail,

I. *Pseudogonococcic or Catarrhal Urethritis.*—Onset insidious. Incubation period longer than in gonorrhea, two to eight days. Discharge slight. Subjective symptoms almost absent, resembling a recurrent gonorrhea. Duration, 8-10 days. There is no posterior involvement and no sequel. A cardinal feature is the marked tendency to recurrence. The organism is probably identical with Heimann's pseudogonoccus and Pfeiffer's micrococcus catarrhal. It is rounded, occurs in pairs of which the numbers are unequal in size, is generally extracellular, decolorizes with Gram, but grows in white opaque colonies on ordinary media, as well as serum agar.

II. *Uric Acid Urethritis.*—This is a purely irritative inflammation, caused by the sharp points of the crystals, present in the urine in quantity. Duration and incubation indefinite. Pain and amount of discharge considerable. Subsides under appropriate treatment.

III. *Streptococcic (?) Urethritis.*—A single case to which some doubt attaches since some of the organisms decolorized by Gram. They were intra- and extracellular diplococci. The only cultures obtained gave the streptococcus in a pure state. The disease ran an unusual course. Although there had been no previous urethritis, there was no sign of virulence, discharge slight, no pain, no posterior inflammation, incubation five days. Discharge disappeared after seven days of irregular treatment, but began again and continued for four weeks, with the same character. Two weeks after the urine was absolutely clear, the patient developed a slight bursitis at the elbow and an arthritis at the wrist which lasted only a few days. The diplococci in smears were extra- and intracellular. The cultures showed no colonies of gonococci and smears from them, typical streptococcic chains. Goldberg has reported a urethritis from the same cause.

IV. *Staphylococcic Urethritis.*—One case; staphylococcus albus recovered in pure culture. Contagion was traced to the mouth of a prostitute as in the French cases. Discharge, which was slight, appeared after three days and was purulent, contrary to Malherbe's observation, by which it was determined to be sero-sanguinolent.

V. Lastly, there are certain cases which suggests, may be called *toxinic,* in which the infection lies in bladder, prostate or kidney. The discharge is purulent and free from organisms. It is intermittent and not painful. One case of author's seemed to depend on a cystitis, the infective agent being Friedlander's pneumobacillus.

It should be remembered that all the typical cases occurred in urethras previously free from disease.

DR. SWINBURNE.—I agree with Dr. Johnston's statements very thoroughly. I saw several of these cases and have seen very similar cases myself, and the main point is the fact that they are cases with primary urethritis. Usually young men with their first attack of urethritis are not seen early in the disease, nevertheless there are men who on contracting the slightest discharge and for the first time in their lives, want to consult someone who can give them good advice, and I have seen in the last few years a large number of cases coming within the first 24 hours of their primary discharge and the study of these cases has been a very interesting one, although I am sorry to say that has not been con-

ducted with culture tests as well as microscopical examinations; and as far as the last case mentioned by Dr. Johnson as the aseptic is concerned, I think that he simply meant that such cases simply show no micro-organisms and not that there was not something underlying either deeper in the urethra, in the bladder or the prostate, which caused this aseptic urethritis. In fact, that is, I think what one should do. He should seek to know what the source of infection is and be extremely suspicious of an aseptic discharge, for most frequently I think he will find its cause in the posterior urethra, the prostate, or the bladder.

DR. GOLDENBERG.—I have been listening to Dr. Johnston's very interesting paper with great delight. The most practical and important conclusion I draw from this paper is that in the future we cannot rely on the ordinary tests for gonococci, not even on the culture test with serum agar. For if other cocci which cause a clinical picture similar to the one in gonorrhoic urethritis grow in the same manner as Neisser's diplococcus it will be necessary in order to identify the coccus as the gonococcus, after a positive result on serum agar, to sow it on ordinary culture media on which the gonococcus, as a rule, does not grow.

DR. FERD. C. VALENTINE.—I confess that reading the title of Dr. Johnston's paper evoked some doubt. Non-gonorrheal urethritis, called by some aseptic inflammation, certainly could not be offered for discussion except to urge the great value of abstinence from treatment. The scientific views so ably presented, however, come as a revelation, although they emphasize in a better manner than I could the results of my personal experience. It is the danger of deciding erroneously in a case which presents no microscopic cause for the discharge in which the value of cultures is particularly emphasized. This is especially the case in that ever-increasing number of former patients who come for an examination, as a preliminary to consent of marriage. I am glad to avail myself of Dr. Johnston's paper to emphasize the need of repeated cultures before one gonorrheic. The subject as presented by Dr. Johnston is too vast for unprecan positively decide upon the permissibility of marriage in the case of an expared discussion. I anticipate, with pleasure, the benefit and privilege of studying this valuable contribution to science, when it is published.

DR. F. TILDEN BROWN.—I was much interested in Dr. Johnston's paper, I have no data of sufficient accuracy to add anything but general comments, one of which is that we could do much to increase the prestige of this section of the academy and much to confirm or dispel our existing views regarding the contention of the admirable paper we have just heard, if in the future we would present every case of suspected pseudo gonorrhea at the earliest possible date after recovery, so that all may have the chance of observing the condition at each stage and of studying the case by his own microscopical and bacteriological methods. It would be of interest to see how many cases would be presented to this section in the course of a year, and accepted by its experts, as belonging to the infectious but non-gonorrheal type. I have seen not more than a dozen such cases, but more of these were ones where the micro-organisms resembled Neisser's Diplococcus in Morphology, staining, or cellular arrangement sufficiently to be confounded with it. I do not wish to contend that there are not in existence cases where nothing short of culture tests can permit a differential diagnosis, but it is the speaker's impression that he has not yet had the fortune to meet one, while on the other hand he feels that the error he has made several times of failing to detect gonococci in cases of urethritis is much more common than that of mistaking a pseudo gonorrhea for one of the specific type.

Dr. Martin W. Ware.—I have listened to Dr. Johnston's paper with a great deal of interest because I, too, was on the lookout for these so-called non-specific urethrites and the bacteria held responsible for them, but after systematic examination of a large number of cases I have come to the conclusion that they are almost non-existing in bona fide urethritis. I do not place any reliance on the formal statements of my patients. I am very strongly influenced by the clinical appearance of the case. For the cultivation of the gonococcus I have found the Wertheim medium to be very practical. This consists of an ordinary slant of agra on whose surface there is spread a thin layer of human blood abstracted from one's own finger under aseptic precautions. This medium is then placed in the thermostat for 24 hours to make sure that it is absolutely sterile.

Concerning the bacteria found by Dr. Johnston, the question comes up whether these organisms are parasitic or pathogenic, since any organism which is specific enough to produce a distinct type of urethritis must conform to the postulates of Koch. This is our attitude in the instance of the gonococcus. If we credit to other bacteria the properties of provoking a distinct urethritis, behaving in all respects clinically like gonorrhœa, we are simply taking a step backward and despoiling the gonococcus of its specific property. The urethra, as we all know, harbors a host of bacteria, and it is therefore incumbent upon us to be able to exclude the fact that these organisms have not wandered into the urethra from the prostate, bladder and adjoining viscera. Thus I recall an instance in which I encountered in a urethral discharge a capsule bacillus in an old gentleman afflicted with enlarged prostate. The latter organ was the source of this capsule bacillus. On the other hand, if we find the bacillus coli in the urethral discharge, we cannot attribute the infection to the female, whose vagina normally harbors the coli.

As to an aseptic urethritis I fail to understand the possibility of its existence since even the normal urethra at all times contains an extensive flora of bacteria.

In conclusion, to demonstrate how specific an organism the gonoccoccus is, I wish to cite a case of a young boy, whose urethral discharge was the source of much speculation for several days. He was but 6 years of age and no venereal contact could be elicited. With the lapse of time a calculus was discovered in the deeper portion of the urethra. While the discharge persisted all this time, instantly following its removal it may be said to have ceased. In the pus of this discharge we found preponderating staphylococci, which casual observations might easily have credited as being responsible for the urethritis; but the removal of the mechanical cause of irritation put an end to the discharge. With the gonococcus present we certainly know the discharge would have persisted.

Dr. Van der Poel.—I would like to reiterate what Dr. Brown has said in regard to the presentation of specimens. It would be far more instructive and interesting not only to the section, but to the general profession, if preparations and cultures could be brought here and exhibited to the Section. It is undoubtedly some trouble to bring microscopes, but I think the result would thoroughly warrant the trouble that was expended in so doing.

Dr. Johnston.—If I remember my remarks correctly I have said nothing about an aseptic discharge. I suggested that it might be called toxinic. The case I saw was one in which the bladder was infected with the bacillus of Friedlander. These cases are not aseptic. The posterior urethra, the prostate, the bladder and the pelvis of the kidney are generally all infected at once. It may be that it is the toxins which, according to Albarran's theory, irritate the urethra exactly as uric acid does in uric acid urethritis.

With regard to my cases we were not any of us born yesterday. We know just how much human testimony is to be depended upon even when people are trying to tell the truth. I deliberately selected these cases from private patients and from personal friends, men whom I knew. It is extremely unlikely, knowing the importance of the history in cases of gonorrhea, having had it explained to them that they would hardly conceal from me the fact that they had had previous gonorrhea, so I am as fairly certain as we can be from any human testimony that we are dealing with urethras previously unaffected. If you cannot believe these people we cannot believe anyone.

With regard to animal inoculation with these organisms, it is a well known fact that the organisms which prey upon the human body do not prey upon the lower animals; that dogs and rabbits are not susceptible to these effects. It is all very well to demand that all postulates of Koch shall be fulfilled in these investigations. It would be just about as easy to demand that the tubercle bacillus should be inoculated upon the human skin and lupus vulgaris produced. There is a certain limit, gentlemen, to investigation and the limit comes when you reinoculate an organism into the human body. The time will not come, I will venture to predict, when that will ever obtain, so that in the interim we shall have to do the best that we can without it; but when you have a series of 8 cases where you recover not a variety of organisms but one single organism which decolorizes with Gram, but grows upon all media, we may be very fairly sure we are dealing with a specific bacterium, which in all probability stands in close etiological relationship with the discharge. The clinical symptoms in the case are just as clearly marked as the morphology of the parasite. This I need not review any further.

With regard to culture Dr. Goldenberg is entirely correct. It is not enough to cultivate any urethral organism upon a medium which contains human serum. It must be seen whether it grows upon ordinary medium also. These organisms grew on ordinary media. The gonococcus does not. With regard to the case of streptococcic urethritis you notice how closely that photograph represents the picture in the early stage of an acute gonorrhœa of a paired coccus partly discolorizing with Gram. If the gonococcus was present, its growth was completely choked off from this beginning and the cultural bacteria showed chains only. The clinical course was certainly not that of a first gonorrhea.

We are not telling the world anything new, in saying that all that runs is not gonorrhea. It is perfectly well known and these cases ought to be, it seems to me, determined in future when this question of marriage comes up. If you are not dealing with gonorrhea your patient may get married. He may transmit this catarrhal infection to his wife, but it will do her no harm, as the gonococcus would. It may get up a leucorrhea, but will not cause the unfortunate sequels common in blenorrhea of the female genitals.

With regard to the presentation of such cases it is a pretty difficult matter. These investigations are not such as can be carried on in public practice, and private patients will not be exhibited. Cultures and smears might be but the former are rarely characteristic and the latter as deceptives, even with Gram.

As to the Gram method itself everybody knows what it is. It varies somewhat in different hands, but the essentials remain the same, variation occurring chiefly in the length of time the solutions are allowed to act. I use it as Finger does.

Selections.

GENITO-URINARY DISEASES.

Intra-Peritoneal Rupture of the Bladder.—By JAMES PEDERSEN, M.D. (*N. Y. Medical Record*, March 22, 1902, p. 475).

Pedersen reports a case in which intra-peritoneal rupture of the bladder occurred as the result of a fall from a window. A small quantity of blood at the meatus directed attention to the possibility of bladder injury, and in the course of examination, seven ounces of boric solution, injected for diagnostic purposes, were lost, showing extravasation. Suprapubic cystotomy was performed nine hours after the injury, and on opening the peritoneum a transverse rent in the bladder was found, two and a half to three inches long. The edges of the wound were brought together closely, with a continuous suture of chromicised catgut. The membranous urethra was then buttonholed, and a 35 F. perineal drainage tube was inserted through it into the bladder.

Examination of the penile urethra for strictures was negative; but a meatotomy was performed, owing to a narrowing at the meatus, for the purpose of relieving the bladder of all unnecessary strain in voiding the urine. The patient made an uneventful recovery. A. L. W.

Prostatectomy by the Perineal Route.—By PARKER SYMS, M.D. (*Annals of Surgery*, April, 1902, p. 467).

Prostatectomy performed through the perineum without opening the bladder suprapubically, is safer than the procedures which do involve suprapubic cystotomy. There is less cutting, less time involved, and the danger of infection which would arise from exposing the prevesical space to the contaminating influence of infected urine, is avoided. After the operation, drainage is carried on entirely through the perineum and in the line of gravitation.

The author's proposed modification of Alexander's operation, namely, that a laparotomy should be performed just above the bladder fold but not opening this organ, whereby one might push the prostate, bladder and all, towards the perineal wound, he never put into practice (for reasons not stated); but an important modification of this proposition by Alexander Johnson, has been successfully carried out since October, 1899. He makes an opening into the prevesical space below the peritoneal fold, whereby he can introduce the finger without opening the bladder.

As a further aid to perineal prostatectomy, the author calls attention to his "bladder retractor." It consists of a rubber tube having a calibre of 38 French, with a rubber bulb attached to one end, which can be dilated by the introduction of two and a half ounces of water, after it has been introduced into the bladder. The method of using this retractor is described in detail.

An instrument devised by J. W. S. Gouley, as a further aid to perineal prostatectomy is also described. It is like a double curved bladder staff with an expanded flat distal extremity. It is introduced through a previously made opening in the membranous portion of the urethra, into the bladder, and is used for making counterpressure from within. Syms believes it will be found to be a valuable aid in many cases.

The after treatment of perineal prostatectomy is simple. A drainage tube is inserted through the opening into the membranous urethra into the bladder, and is retained in position by one stitch. All the wound is carefully packed around this tube, the bladder being kept clean by repeated washings, and emptied by continuous drainage. On the fifth to seventh day the drainage tube is removed and the patients are usually out of bed by the seventh to the tenth day. During the healing process the anterior urethra must be irrigated frequently, and as soon as the wound has begun to fill up with granulations, a full sized sound should be introduced into the bladder, at first every three days, afterwards at more frequent intervals. This is continued for from three to six weeks.

The author has thus far done thirteen prostatectomies, with satisfactory results. Prostatectomy should be done early and not as a last resort, the perineal route being the safest method thus far proposed. A. L. W.

Suprapubic Cystotomy in Operations upon the Bladder.—By HOWARD LILIENTHAL, M.D. (*Medical Record*, Jan. 18, 1902, page 88).

Lilienthal reports seven cases in which he performed suprapubic enucleation of the hypertrophied prostate, with one death, one failure, and five complete cures. He urges that as a general rule, with few exceptions, the first step in the operative cure of any form of prostatic obstruction, should be a suprapubic cystotomy, even if it should later become evident that the disease itself must be attacked from some other quarter. It is the only way in which certain information as to the condition of the bladder can be obtained.

The value of the cystoscope for this purpose is limited, and in certain forms it cannot be used at all. Galvanocaustic prostatotomy (Bottini), unless preceded by suprapubic section involves the risk that serious bladder lesions may exist unknown, which may nullify the expected benefit. The additional advantage of bladder drainage is also obtained by the operation, when cystitis exists. A case is mentioned in which cystoscopy was impossible, owing to excessive hemorrhage. Diagnosis of possible hypertrophied prostate was made. Suprapubic cystotomy, made for exploratory purposes, revealed a carcinoma of the prostate. The tumor was curetted, with satisfactory result, for some months. The suprapubic wound healed quickly.

If a prostate, on examination through the bladder wound, is very soft and hyperemic, or of such texture that it cannot be enucleated, one has the choice of the Bottini operation, or of removal with the cutting forceps by conjoined manipulation. In any case, the bladder opening is of the greatest value. The bleeding is much less than with perineal section, shock is comparatively small, and the operation takes but a few minutes. A. L. W.

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